General

Guideline Title

Heel pain—plantar fasciitis: revision 2014.

Bibliographic Source(s)

Martin RL, Davenport TE, Reischl SF, McPoil TG, Matheson JW, Wukich DK, McDonough CM, American Physical Therapy Association. Heel pain-plantar fasciitis: revision 2014. J Orthop Sports Phys Ther. 2014 Nov;44(11):A1-33. [100 references] PubMed

Guideline Status

This is the current release of the guideline.

This guideline updates a previous version: McPoil TG, Martin RL, Cornwall MW, Wukich DK, Irrgang JJ, Godges JJ. Heel pain--plantar fasciitis: clinical practice guidelines linked to the International Classification of Function, Disability, and Health from the Orthopaedic Section of the American Physical Therapy Association. J Orthop Sports Phys Ther. 2008 Apr;38(4):A1-18. [61 references]

This guideline meets NGC's 2013 (revised) inclusion criteria.

Recommendations

Major Recommendations

Levels of evidence (I–V) and grades of recommendation (A–F) are defined at the end of the "Major Recommendations" field.

Note: These recommendations and clinical practice guidelines are based on the scientific literature published prior to January 2013.

Risk Factors

Clinicians should assess the presence of limited ankle dorsiflexion range of motion, high body mass index in nonathletic individuals, running, and work-related weight-bearing activities—particularly under conditions with poor shock absorption—as risk factors for the development of heel pain/plantar fasciitis. (Grade of Recommendation: B)

Diagnosis/Classification

Physical therapists should diagnose the International Classification of Diseases (ICD) category of plantar fasciitis and the associated International Classification of Functioning, Disability and Health (ICF) impairment-based category of heel pain (b28015 Pain in lower limb, b2804 Radiating pain in a segment or region) using the following history and physical examination findings:

- Plantar medial heel pain: most noticeable with initial steps after a period of inactivity but also worse following prolonged weight bearing
- Heel pain precipitated by a recent increase in weight-bearing activity

- Pain with palpation of the proximal insertion of the plantar fascia
- Positive windlass test
- Negative tarsal tunnel tests
- Limited active and passive talocrural joint dorsiflexion range of motion
- Abnormal Foot Posture Index score
- High body mass index in nonathletic individuals

(Grade of Recommendation: B)

Differential Diagnosis

Clinicians should assess for diagnostic classifications other than heel pain/plantar fasciitis, including spondyloarthritis, fat-pad atrophy, and proximal plantar fibroma, when the individual's reported activity limitations or impairments of body function and structure are not consistent with those presented in the Diagnosis/Classification section of the original guideline document, or when the individual's symptoms are not resolving with interventions aimed at normalization of the individual's impairments of body function. (Grade of Recommendation: C)

Examination

Outcome Measures

Clinicians should use the Foot and Ankle Ability Measure (FAAM), Foot Health Status Questionnaire (FHSQ), or the Foot Function Index (FFI) and may use the computer-adaptive version of the Lower Extremity Functional Scale (LEFS) as validated self-report questionnaires before and after interventions intended to alleviate the physical impairments, activity limitations, and participation restrictions associated with heel pain/plantar fasciitis. (Grade of Recommendation: A)

Activity Limitation and Participation Restriction Measures

Clinicians should utilize easily reproducible performance-based measures of activity limitation and participation restriction measures to assess changes in the patient's level of function associated with heel pain/plantar fasciitis over the episode of care. (Grade of Recommendation: F)

Physical Impairment Measures

When evaluating a patient with heel pain/plantar fasciitis over an episode of care, assessment of impairment of body function should include measures of pain with initial steps after a period of inactivity and pain with palpation of the proximal insertion of the plantar fascia, and may include measures of active and passive ankle dorsiflexion range of motion and body mass index in nonathletic individuals. (Grade of Recommendation: B)

Interventions

Manual Therapy

Clinicians should use manual therapy, consisting of joint and soft tissue mobilization, procedures to treat relevant lower extremity joint mobility and calf flexibility deficits and to decrease pain and improve function in individuals with heel pain/plantar fasciitis. (Grade of Recommendation: A)

Stretching

Clinicians should use plantar fascia–specific and gastrocnemius/soleus stretching to provide short-term (1 week to 4 months) pain relief for individuals with heel pain/plantar fasciitis. Heel pads may be used to increase the benefits of stretching. (Grade of Recommendation: A)

Taping

Clinicians should use antipronation taping for immediate (up to 3 weeks) pain reduction and improved function for individuals with heel pain/plantar fasciitis. Additionally, clinicians may use elastic therapeutic tape applied to the gastrocnemius and plantar fascia for short-term (1 week) pain reduction. (Grade of Recommendation: A)

Foot Orthoses

Clinicians should use foot orthoses, either prefabricated or custom fabricated/fitted, to support the medial longitudinal arch and cushion the heel in individuals with heel pain/plantar fasciitis to reduce pain and improve function for short- (2 weeks) to long-term (1 year) periods, especially in those individuals who respond positively to antipronation taping techniques. (Grade of Recommendation: A)

Night Splints

Clinicians should prescribe a 1- to 3-month program of night splints for individuals with heel pain/plantar fasciitis who consistently have pain with the first step in the morning. (Grade of Recommendation: A)

Physical Agents

Electrotherapy

Clinicians should use manual therapy, stretching, and foot orthoses instead of electrotherapeutic modalities, to promote intermediate and long-term (1-6 months) improvements in clinical outcomes for individuals with heel pain/plantar fasciitis. Clinicians may or may not use iontophoresis with dexamethasone or acetic acid to provide short-term (2-4 weeks) pain relief and improved function. (Grade of Recommendation: D)

Low-Level Laser

Clinicians may use low-level laser therapy to reduce pain and activity limitations in individuals with heel pain/plantar fasciitis. (Grade of Recommendation: C)

Phonophoresis

Clinicians may use phonophoresis with ketoprofen gel to reduce pain in individuals with heel pain/plantar fasciitis. (Grade of Recommendation: C)

Ultrasound

The use of ultrasound cannot be recommended for individuals with heel pain/plantar fasciitis. (Grade of Recommendation: C)

Footwear

To reduce pain in individuals with heel pain/plantar fasciitis, clinicians may prescribe (1) a rocker-bottom shoe construction in conjunction with a foot orthosis, and (2) shoe rotation during the work week for those who stand for long periods. (Grade of Recommendation: C)

Education and Counseling for Weight Loss

Clinicians may provide education and counseling on exercise strategies to gain or maintain optimal lean body mass in individuals with heel pain/plantar fasciitis. Clinicians may also refer individuals to an appropriate health care practitioner to address nutrition issues. (Grade of Recommendation: E)

Therapeutic Exercise and Neuromuscular Re-education

Clinicians may prescribe strengthening exercises and movement training for muscles that control pronation and attenuate forces during weight-bearing activities. (Grade of Recommendation: F)

Dry Needling

The use of trigger point dry needling cannot be recommended for individuals with heel pain/plantar fasciitis.

Definitions

Levels of Evidence

Individual clinical research articles were graded according to criteria described by the Centre for Evidence-Based Medicine, Oxford, United Kingdom.

I	Evidence obtained from high-quality diagnostic studies, prospective studies, or randomized controlled trials
II	Evidence obtained from lesser-quality diagnostic studies, prospective studies, or randomized controlled trials (e.g., weaker diagnostic criteria and reference standards, improper randomization, no blinding, less than 80% follow-up)
III	Case-controlled studies or retrospective studies
IV	Case series
V	Expert opinion

Grades of Recommendation Based on Strength of Evidence

Grades of Recommendation		Strength of Evidence
A	Strong evidence	A preponderance of level I and/or level II studies support the recommendation. This must include at least 1 level I study.
B	Moderate evidence	A single high-quality randomized controlled trial or a preponderance of level II studies support the recommendation
C	Weak evidence	A single level II study or a preponderance of level III and IV studies, including statements of consensus by content experts, support the recommendation
D	Conflicting evidence	Higher-quality studies conducted on this topic disagree with respect to their conclusions. The recommendation is based on these conflicting studies.
E	Theoretical/foundational evidence	A preponderance of evidence from animal or cadaver studies, from conceptual models/principles, or from basic sciences/bench research support this conclusion
F	Expert opinion	Best practice based on the clinical experience of the guidelines development team

Clinical Algorithm(s)

None provided

Scope

Disease/Condition(s)

- Plantar fasciitis
- Heel pain

Guideline Category

Diagnosis

Evaluation

Management

Risk Assessment

Treatment

Clinical Specialty

Family Practice

Orthopedic Surgery

Physical Medicine and Rehabilitation

Podiatry

Sports Medicine

Intended Users

Physical Therapists

Physicians

Podiatrists

Students

Utilization Management

Guideline Objective(s)

- To describe evidence-based physical therapy practice including diagnosis, prognosis, intervention, and assessment of outcome for musculoskeletal disorders commonly managed by orthopaedic physical therapists
- To classify and define common musculoskeletal conditions using World Health Organization terminology related to impairments of body function and body structure, activity limitations, and participation restrictions
- To identify interventions supported by current best evidence to address impairments of body function and structure, activity limitations, and participation restrictions associated with common musculoskeletal conditions
- To identify appropriate outcome measures to assess changes resulting from physical therapy interventions in body function and structure, as well as in activity and participation of the individual
- To provide a description to policy makers, using internationally accepted terminology, of the practice of orthopaedic physical therapists
- To provide information for payers and claims reviewers regarding the practice of orthopaedic physical therapy for common musculoskeletal conditions
- To create a reference publication for orthopaedic physical therapy clinicians, academic instructors, clinical instructors, students, interns, residents, and fellows regarding the best current practice of orthopaedic physical therapy

Target Population

Patients with heel pain or plantar fasciitis

Interventions and Practices Considered

Diagnosis/Evaluation/Risk Assessment

1. Risk factor assessment
2. Diagnosis and classification according to International Statistical Classification of Diseases (ICD) criteria and International Classification of Functioning, Disability, and Health (ICF) criteria
3. Differential diagnosis
4. Physical examination
    - Outcome measures: Foot and Ankle Ability Measure (FAAM), Foot Health Status Questionnaire (FHSQ), Foot Function Index (FFI), computer-adaptive version of the Lower Extremity Functional Scale (LEFS)
    - Performance-based measures of activity limitation and participation restriction measures
    - Physical impairment measures

Treatment/Management

1. Manual therapy
2. Plantar fascia–specific and gastrocnemius/soleus stretching
3. Taping: antipronation taping or elastic therapeutic tape applied to the gastrocnemius and plantar fascia
4. Prefabricated or custom foot orthoses
5. Night splints
6. Physical agents
    - Electrotherapy (iontophoresis with dexamethasone or acetic acid for short-term use)
    - Low-level laser therapy
    - Phonophoresis with ketoprofen gel
7. Footwear

8. Education and counseling for weight loss
9. Therapeutic exercise and neuromuscular re-education

Note: The following were considered but not recommended: ultrasound and trigger point dry needling.

Major Outcomes Considered

- Incidence and prevalence of ankle and foot overuse injuries in sports
- Validity, reliability, and responsiveness of rating scales for function and pain
- Pain relief
- Ankle dorsiflexion range of motion
- Functional outcomes scores
- Mobility
- Relationship between body mass index (BMD) and foot disorders

Methodology

Methods Used to Collect/Select the Evidence

Hand-searches of Published Literature (Primary Sources)

Searches of Electronic Databases

Description of Methods Used to Collect/Select the Evidence

The authors of this guideline revision worked with research librarians with expertise in systematic review to perform a systematic search for concepts associated with heel pain or plantar fasciitis in articles published since 2007 related to classification, examination, and intervention strategies for heel pain or plantar fasciitis, consistent with previous guideline development methods related to International Classification of Functioning, Disability and Health (ICF) classification. Briefly, the following databases were searched from 2007 to between December 13 and 19, 2012: MEDLINE (PubMed) (2007 to date), Cochrane Library (2007 to date), Web of Science (2007 to date), CINAHL (2007 to date), ProQuest Dissertations and Theses (2007 to date), PEDro (2007 to date), and ProQuest Nursing and Allied Health Source (2007 to date). See Appendix A and Appendix B in the original guideline document for full search strategies and search dates and results, respectively.

Articles contributing to recommendations were reviewed based on specified inclusion and exclusion criteria (see Appendix C in the original guideline document), with the goal of identifying evidence relevant to physical therapist clinical decision making for adult persons with heel pain/plantar fasciitis. The title and abstract of each article were reviewed independently by 2 members of the clinical practice guideline (CPG) development team for inclusion. Full-text review was then similarly conducted to obtain the final set of articles for contribution to recommendations. The team leader provided the final decision for discrepancies that were not resolved by the review team. See Appendix D for a flow chart of articles and Appendix E for articles included in recommendations by topic (see the original guideline document for appendices). For selected relevant topics that were not appropriate for the development of recommendations, such as shockwave therapy, injection, and imaging, articles were not subject to the systematic review process and were not included in the flow chart.

Number of Source Documents

A total of 81 articles were used for development of recommendations.

See Appendix D in the original guideline document for a flow chart of the article selection process.

Methods Used to Assess the Quality and Strength of the Evidence

Weighting According to a Rating Scheme (Scheme Given)

Rating Scheme for the Strength of the Evidence

Levels of Evidence

Individual clinical research articles were graded according to criteria described by the Centre for Evidence-Based Medicine, Oxford, United Kingdom.

I	Evidence obtained from high-quality diagnostic studies, prospective studies, or randomized controlled trials
II	Evidence obtained from lesser-quality diagnostic studies, prospective studies, or randomized controlled trials (e.g., weaker diagnostic criteria and reference standards, improper randomization, no blinding, less than 80% follow-up)
III	Case-controlled studies or retrospective studies
IV	Case series
V	Expert opinion

Methods Used to Analyze the Evidence

Review of Published Meta-Analyses

Systematic Review with Evidence Tables

Description of the Methods Used to Analyze the Evidence

Individual clinical research articles were graded according to criteria adapted from the Centre for Evidence-based Medicine, Oxford, UK for diagnostic, prospective, and therapeutic studies. In 3 teams of 2, each reviewer independently assigned a level of evidence and evaluated the quality of each article using a critical appraisal tool. See Appendices F and G in the original guideline document for the evidence table and details on procedures used for assigning levels of evidence. An abbreviated version of the grading system is provided in the "Rating Scheme for the Strength of the Evidence" field.

Methods Used to Formulate the Recommendations

Expert Consensus

Description of Methods Used to Formulate the Recommendations

Content experts were appointed by the Orthopaedic Section of the American Physical Therapy Association (APTA) to conduct a review of the literature and to develop an updated heel pain/plantar fasciitis clinical practice guideline (CPG) as indicated by the current state of the evidence in the field. The aims of the revision were to provide a concise summary of the evidence since publication of the original guideline and to develop new recommendations or revise previously published recommendations to support evidence-based practice.

The strength of the evidence supporting the recommendations was graded according to the previously established methods for the original guideline and those provided in the "Rating Scheme for the Strength of the Recommendations" field. Each team developed recommendations based on the strength of evidence, including how directly the studies addressed the question and heel pain/plantar fasciitis population. In developing their recommendations, the authors considered the strengths and limitations of the body of evidence and the health benefits, side effects, and risks of tests and interventions.

Rating Scheme for the Strength of the Recommendations

Grades of Recommendation Based on Strength of Evidence

Grades of Recommendation	Strength of Evidence

Grades of Recommendation		Strength of Evidence
A	Strong evidence	A preponderance of level I and/or level II studies support the recommendation. This must include at least 1 level I study.
B	Moderate evidence	A single high-quality randomized controlled trial or a preponderance of level II studies support the recommendation
C	Weak evidence	A single level II study or a preponderance of level III and IV studies, including statements of consensus by content experts, support the recommendation
D	Conflicting evidence	Higher-quality studies conducted on this topic disagree with respect to their conclusions. The recommendation is based on these conflicting studies.
E	Theoretical/foundational evidence	A preponderance of evidence from animal or cadaver studies, from conceptual models/principles, or from basic sciences/bench research support this conclusion
F	Expert opinion	Best practice based on the clinical experience of the guidelines development team

Cost Analysis

A formal cost analysis was not performed and published cost analyses were not reviewed.

Method of Guideline Validation

External Peer Review

Internal Peer Review

Description of Method of Guideline Validation

Review Process

The Orthopaedic Section, American Physical Therapy Association (APTA) selected content experts and stakeholders to serve as reviewers of the early drafts of these clinical practice guidelines (CPGs). The draft was posted for public comment on the Web site of the Orthopaedic Section of the APTA. The authors used the feedback from the reviewer and website comments to inform final revisions.

Evidence Supporting the Recommendations

Type of Evidence Supporting the Recommendations

The type of supporting evidence is identified and graded for each recommendation (see "Major Recommendations" field).

Benefits/Harms of Implementing the Guideline Recommendations

Potential Benefits

- Treatment directed to reducing plantar fascia strain has been shown to be effective in reducing pain with initial steps and palpation of the proximal insertion of the plantar fascia.
- A randomized clinical trial found that soft tissue mobilization techniques directed to the musculature of the lower leg were associated with improved disability and pressure pain threshold measurements in individuals with plantar heel pain.
- In patients with plantar fasciitis, antipronation (low-Dye) taping was found to reduce pain and improve function over a 3-week period. Also, antipronation taping (augmented low-Dye) produced an immediate decrease in mean walking plantar pressure and pain when walking and jogging.
- One study found prefabricated semi-rigid foot orthoses to have a moderately beneficial effect compared to sham foot orthoses in reducing pain and improving function over a 3- to 12-month period in individuals with plantar fasciitis compared with the controls. Another study

reported that both prefabricated and custom orthoses were useful in distributing rearfoot pressure, whereas heel pads increased rearfoot pressure.

Refer to the evidence sections in the original guideline document for more information on potential benefits of treatment.

Potential Harms

- One review of calf muscle and/or plantar fascia–specific stretching included a study that noted adverse effects, which included increased pain in the heel, calf, and other areas of the lower limb, in 10 of 46 participants within the calf stretching group.
- Potential harms associated with intralesional corticosteroid injection (ICSI) may include injection-site pain, infection, subcutaneous fat atrophy, skin pigmentation changes, plantar fascia rupture, peripheral nerve injury, and muscle damage.

Refer to the evidence sections in the original guideline document for more information on potential harms of treatment, including interventions that are not recommended.

Qualifying Statements

Qualifying Statements

These guidelines are not intended to be construed or to serve as a standard of medical care. Standards of care are determined on the basis of all clinical data available for an individual patient and are subject to change as scientific knowledge and technology advance and patterns of care evolve. These parameters of practice should be considered guidelines only. Adherence to them will not ensure a successful outcome in every patient, nor should they be construed as including all proper methods of care or excluding other acceptable methods of care aimed at the same results. The ultimate judgment regarding a particular clinical procedure or treatment plan must be made based on clinical experience and expertise in light of the clinical presentation of the patient; the available evidence; the available diagnostic and treatment options; and the patient's values, expectations, and preferences. However, it is suggested that significant departures from accepted guidelines should be documented in the patient's medical records at the time the relevant clinical decision is made.

Implementation of the Guideline

Description of Implementation Strategy

An implementation strategy was not provided.

Implementation Tools

Resources

For information about availability, see the *Availability of Companion Documents* and *Patient Resources* fields below.

Institute of Medicine (IOM) National Healthcare Quality Report Categories

IOM Care Need

Getting Better

Living with Illness

IOM Domain

Effectiveness

Patient-centeredness

Identifying Information and Availability

Bibliographic Source(s)

Martin RL, Davenport TE, Reischl SF, McPoil TG, Matheson JW, Wukich DK, McDonough CM, American Physical Therapy Association. Heel pain-plantar fasciitis: revision 2014. J Orthop Sports Phys Ther. 2014 Nov;44(11):A1-33. [100 references] PubMed

Adaptation

Not applicable: The guideline was not adapted from another source.

Date Released

2014 Nov

Guideline Developer(s)

American Physical Therapy Association, Inc., The Orthopaedic Section - Medical Specialty Society

Source(s) of Funding

The Orthopaedic Section of the American Physical Therapy Association (APTA)

Guideline Committee

Clinical Practice Guideline (CPG) Development Team

Composition of Group That Authored the Guideline

Authors: RobRoy L. Martin, PT, PhD, Professor, Department of Physical Therapy, Duquesne University, Pittsburgh, Pennsylvania, Staff Physical Therapist, Center for Rehab Services, University of Pittsburgh Medical Center, Pittsburgh, Pennsylvania; Todd E. Davenport, DPT, Associate Professor, Department of Physical Therapy, University of the Pacific, Stockton, California; Stephen F. Reischl, DPT, Adjunct Associate Professor of Clinical Physical Therapy, Division of Biokinesiology and Physical Therapy, Herman Ostrow School of Dentistry, University of Southern California, Los Angeles, California, Reischl Physical Therapy, Inc, Signal Hill, California; Thomas G. McPoil, PT, PhD, Professor, School of Physical Therapy, Rueckert-Hartman College of Health Professions, Regis University, Denver, Colorado; James W. Matheson, DPT, President and Clinic Director, Catalyst Sports Medicine, Hudson, Wisconsin; Dane K. Wukich, MD, Chief, Division of Foot and Ankle Surgery, Assistant Professor of Orthopaedic Surgery, University of Pittsburgh Comprehensive Foot and Ankle Center, Pittsburgh, Pennsylvania; Christine M. McDonough, PT, PhD, Research Assistant Professor, Health and Disability Research Institute, Boston University School of Public Health, Boston, Massachusetts, Adjunct Clinical Assistant Professor, Department of Orthopaedic Surgery, Geisel School of Medicine at Dartmouth, Dartmouth-Hitchcock Medical Center, Lebanon, New Hampshire, ICF-based Clinical Practice Guidelines Revisions Coordinator, Orthopaedic Section, APTA, Inc, La Crosse, Wisconsin

Reviewers: Roy D. Altman, MD, Professor of Medicine, Division of Rheumatology and Immunology, David Geffen School of Medicine,

University of California Los Angeles, Los Angeles, California; Paul Beattie, PT, PhD, Clinical Professor, Division of Rehabilitative Sciences, University of South Carolina, Columbia, South Carolina; Mark Cornwall, PT, PhD, Professor, Department of Physical Therapy, Northern Arizona University, Flagstaff, Arizona; Irene Davis, PT, PhD, Director, Spaulding National Running Center, Department of Physical Medicine and Rehabilitation, Harvard Medical School, Spaulding-Cambridge Outpatient Center, Cambridge, Massachusetts; John DeWitt, DPT, Director of Physical Therapy Sports and Orthopaedic Residencies, The Ohio State University, Columbus, Ohio; James M. Elliott, PT, PhD, Assistant Professor, Physical Therapy and Human Movement Sciences, Feinberg School of Medicine, Northwestern University, Chicago, Illinois; James J. Irrgang, PT, PhD, Associate Professor and Director of Clinical Research, Department of Orthopaedic Surgery, University of Pittsburgh School of Medicine, Pittsburgh, Pennsylvania; Sandra Kaplan, PT, PhD, Clinical Practice Guidelines Coordinator, Pediatric Section, APTA, Inc, Alexandria, Virginia, Professor, Doctoral Programs in Physical Therapy, Rutgers University; Stephen Paulseth, DPT, MS, Paulseth and Associates Physical Therapy, Los Angeles, California, Clinical Faculty, Orthopedic Physical Therapy Residency Program, Division of Biokinesiology and Physical Therapy, Herman Ostrow School of Dentistry, University of Southern California, Los Angeles, California; Leslie Torburn, DPT, Principal and Consultant, Silhouette Consulting, Inc, Sacramento, California; James Zachazewski, DPT, Clinical Director, Department of Physical and Occupational Therapy, Clinical Content Lead, Health Professions, Partners eCare, Massachusetts General Hospital, Boston, Massachusetts

Coordinator: Joseph J. Godges, DPT, MA, ICF-based Clinical Practice Guidelines Coordinator, Orthopaedic Section, APTA, Inc, La Crosse, Wisconsin, Adjunct Associate Professor of Clinical Physical Therapy, Division of Biokinesiology and Physical Therapy, Herman Ostrow School of Dentistry, University of Southern California, Los Angeles, California

Financial Disclosures/Conflicts of Interest

The authors declared relationships and developed a conflict management plan, which included submitting a conflict-of-interest form to the Orthopaedic Section of American Physical Therapy Association (APTA). Articles that were authored by a reviewer were assigned to an alternate reviewer. Funding was provided to the clinical practice guideline (CPG) development team for travel and expenses for CPG development training. The CPG development team maintained editorial independence.

Guideline Status

This is the current release of the guideline.

This guideline updates a previous version: McPoil TG, Martin RL, Cornwall MW, Wukich DK, Irrgang JJ, Godges JJ. Heel pain--plantar fasciitis: clinical practice guidelines linked to the International Classification of Function, Disability, and Health from the Orthopaedic Section of the American Physical Therapy Association. J Orthop Sports Phys Ther. 2008 Apr;38(4):A1-18. [61 references]

This guideline meets NGC's 2013 (revised) inclusion criteria.

Guideline Availability

Available from the Journal of Orthopedic and Sports Physical Therapy Web site .

Availability of Companion Documents

A model to guide clinical decisions regarding evaluation, diagnosis, and treatment planning for individuals with heel pain/plantar fasciitis is available in the original guideline document .

Patient Resources

None available

NGC Status

This NGC summary was completed by ECRI Institute on March 24, 2010. The information was verified by the developer on May 9, 2010. This summary was updated by ECRI Institute on January 31, 2017. The updated information was not verified by the guideline developer.

Copyright Statement

Disclaimer

NGC Disclaimer

The National Guideline Clearinghouseâ„¢ (NGC) does not develop, produce, approve, or endorse the guidelines represented on this site.

All guidelines summarized by NGC and hosted on our site are produced under the auspices of medical specialty societies, relevant professional associations, public or private organizations, other government agencies, health care organizations or plans, and similar entities.

Guidelines represented on the NGC Web site are submitted by guideline developers, and are screened solely to determine that they meet the NGC Inclusion Criteria.

NGC, AHRQ, and its contractor ECRI Institute make no warranties concerning the content or clinical efficacy or effectiveness of the clinical practice guidelines and related materials represented on this site. Moreover, the views and opinions of developers or authors of guidelines represented on this site do not necessarily state or reflect those of NGC, AHRQ, or its contractor ECRI Institute, and inclusion or hosting of guidelines in NGC may not be used for advertising or commercial endorsement purposes.

Readers with questions regarding guideline content are directed to contact the guideline developer.